STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING _____ B. WING _____	C 02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF LAFAYETTE	**300 WINDY HILL DR LAFAYETTE, IN 47905**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00142785 and Complaint #IN00144395. Complaint #IN00142785- Unsubstantiated due to lack of evidence. Complaint #IN00144395- Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 24 & 25, 2014 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Survey team: Michelle Carter, RN Census bed type: SNF/NF- 105 Total- 105 Census payor type: Medicare- 13 Medicaid- 74 Other- 18 Total- 105 Sample: 4 Signature Healthcare of Lafayette was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint #IN00142785 and Complaint #IN00144395.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review 02/26/14 by Lisa McColly	F 000		